Vermont Freedom Plan Certificate of Coverage

BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

This is your Certificate of Coverage, a part of your Contract.

These documents make up your Contract, which governs your benefits:

- This ***Certificate of Coverage,*** which describes your benefits in detail and gives requirements, limitations and exclusions for coverage.
- Your ***Outline of Coverage***, which shows what you must pay providers and lists services that require Prior Approval.
- Any **riders** or **endorsements** listed on your ***Outline of Coverage.*** They describe additional coverage or changes to your Contract.
- Your ***ID Card***.
- Your ***Group Enrollment Form*** **(your application)** and any supplemental applications that you submitted and we approved.

If you're missing part of your Contract, call customer service and request another copy. We sometimes replace a part of your Contract without replacing it all. This Certificate is current until we replace it. If the description of benefits in your Contract differs from the descriptions in other materials we provide, the language in your Contract governs.

How to Use This Document

1. Read Chapter One, "How We Determine Your Benefits." Information there applies to all services.
2. Find the service you need in Chapter Two, "Covered Services." You may use the Index or Table of Contents to find it. Read the section thoroughly.
3. Check "General Exclusions" to be sure the service you need is not on this list.
4. To find out what you must pay for a service or supply, check your *Outline of Coverage*.
5. Please remember that to know the full terms of your coverage, you should read your entire Contract.
6. Some terms in your Certificate have special meanings. We capitalize these terms in the text. We define them in the last chapter of this booklet. Read "Definitions" to fully understand your coverage.

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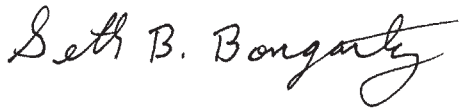
After we accept your application, we provide benefits for the health care services in your Contract, subject to all Contract conditions.

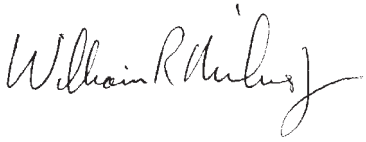
Coverage continues from month to month until your Contract is discontinued, terminated or voided as allowed by its provisions. (See Chapters Seven and Eight.)

Note:

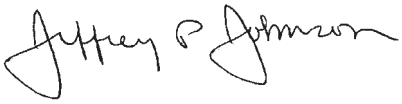
This Certificate is not a Medicare Supplement Contract. If you are eligible for Medicare, please review the *Medicare Supplement Buyer's Guide* available from the company.



Seth B. Bongartz
Board Chair



William R. Milnes, Jr.
President



Jeffrey P. Johnson
Secretary

Chapter One
How We Determine Your Benefits

This Chapter shows how we cover services under your Contract. While reading about your coverage, please keep these facts in mind:

- Some terms in your Certificate have special meanings. We capitalize these terms in the text. We define them in the last chapter of this booklet. Read Definitions to fully understand your coverage.
- In addition to the exclusions in each section, there are general exclusions to your coverage, which we list in Chapter Three.
- To receive benefits, you must use covered Providers (see our definition). For some services, the Providers must be Preferred. For other services, Providers must belong to one of our Networks. We must deem services Medically Necessary.
- Subject to your rights under this Contract and the law that allows you to appeal a denial of benefits, we have the authority to interpret and apply the terms of this Contract and to determine whether and to what extent you have coverage for a requested service, even when a Provider has prescribed or recommended the service.
- You must follow the guidelines in this Certificate even if this coverage is secondary to other health care coverage for you or one of your Dependents.

How We Determine Our Payments

This Chapter explains how we pay your benefits. When we receive your claim, we determine:

- if this Contract covers your services; and
- your benefit amount.

In general, we pay our Allowed Price (explained below) for the service or supply you receive. We may subtract any:

- benefits paid by Medicare;
- Deductibles (explained below);
- Co-payments or Visit Fees (explained below);
- Coinsurance (explained below); and
- amounts paid or due from other insurance carriers through Coordination of Benefits (refer to Chapter Six).

We may limit benefits to lifetime or calendar year maximums shown on your *Outline of Coverage*.

Payment Terms

Allowed Price

The Allowed Price is the amount we consider a reasonable payment for a Covered service or supply.

Deductible

You must pay Deductibles to Providers each calendar year before we provide benefits for

certain services listed on your *Outline of Coverage*. Please note that you may have more than one Deductible. For example, you may have a higher Deductible for coverage of services by a Nonpreferred Provider. We apply your Deductible toward your Out-of-Pocket Limit for each calendar year. We also apply carryover Deductibles. (See below.)

Some plans limit the amount of Deductible a family must pay in a calendar year. If your plan has a family Deductible, it is listed on your *Outline of Coverage*. When your family meets the family Deductible, all family members are considered to have met their individual Deductibles.

Carryover of Deductible

Any portion of your Deductible applied for services you have after September 30th each calendar year will be applied toward your next year's Deductible as well.

Co-payment (Visit Fee)

You must pay Co-payments or Visit Fees to Providers for specific services shown on your *Outline of Coverage*. Your Provider may require payment at the time of the service. We do not apply Co-payments or Visit Fees toward your Out-of-Pocket Limits.

Coinsurance

You must pay Coinsurance to Providers for certain services listed on your *Outline of Coverage*. We calculate the Coinsurance amount by multiplying the Coinsurance percentage by the Allowed Price after you meet your Deductible. Please note that we may apply a higher Coinsurance amount to coverage of services by a Nonpreferred provider. We apply your Coinsurance toward your Out-of-Pocket Limits for each calendar year.

Out-of-Pocket Limits

After you satisfy your Out-of-Pocket Limit, you pay no Coinsurance for the remainder of the calendar year. Your *Outline of Coverage* lists your Out-of-Pocket Limit. You may have a higher Out-of-Pocket limit for coverage of services by a Nonpreferred Provider.

Calendar Year and Lifetime Benefit Maximums

Your various calendar year and lifetime benefit maximums are listed on your *Outline of Coverage*. After we have provided maximum benefits, you must pay all charges.

Choosing a Provider

You may usually select any provider you want to use for a service you need. For some types of services, you must choose a Preferred Provider or you will have no benefits. For some other services, you must choose a Network provider or you will have no benefits.

For many types of care, you may use Nonpreferred providers (see "Nonpreferred Providers" on page 7). If you do, you may pay more of the cost of your care.

Preferred Providers

Here's how choosing a Preferred Provider helps you:

- Preferred Providers bill us directly for your services, so you don't have to do the paperwork to submit a claim;

- Preferred Providers do not ask for payment at the time of service (except for Deductible, Coinsurance, Co-payments or Visit Fees you owe); and
- Preferred Providers accept our Allowed Price as full payment. You do not have to pay the difference between their total charge and our Allowed Price.

Remember that you may have lower Deductibles and Coinsurance to pay when you use Preferred Providers (see your *Outline of Coverage*) .

Nonpreferred Providers

If you use a Nonpreferred Provider, we pay our Allowed Price and you must pay any balance between the Provider's charge and what we pay. You must also pay Deductibles and Coinsurance, which may be higher for coverage of services by Nonpreferred Providers. (See your *Outline of Coverage*.)

If you use one of the following Providers that is not a Preferred Provider, we will not cover your care and you must pay the full cost:

- Cardiac Rehabilitation Providers;
- Chiropractors;
- Home Infusion Therapy Providers;
- Certified Nurse Midwives;
- Nutritional Counseling providers (including registered dieticians, licensed nutritionists, certified diabetic educators and nurse practitioners);
- Physical Rehabilitation Facilities; and
- Skilled Nursing Facilities.

Out-of-state Providers

Providers located out of state that have a Preferred Provider agreement with another Blue Cross and Blue Shield Plan are also Preferred Providers with us. See "The BlueCard Program" below.

The local Plan determines which Providers are Preferred. In Vermont, these providers are the same as our Participating Providers. In other states, however, Preferred Providers may be only a smaller group of Providers who make special Preferred Provider Contracts with the local Plan. To find out which Providers are Preferred Providers in a given state, you may call the Customer Service Department number listed on your I.D. card or consult a Preferred Provider directory for the region where you will seek service. To obtain a copy of a directory for a Plan in another state, call the BlueCard ACCESS Provider Locator at 1-800-810-BLUE (2583) or visit bluecares.com on the worldwide web.

Network Providers

We have special Networks for some types of Providers. For example, we have a Network of mental health and substance abuse treatment Providers. **You receive mental health and substance abuse treatment benefits only if you use a Provider in our mental health network. The mental health Network of Providers is separate from our Preferred Provider network.**

If you have a Prescription Drug Rider, you may be required to use Network Pharmacies to get coverage for Prescription Drugs. Read all the documents included with your Contract carefully. Your *Outline of Coverage* lists the riders included in your Contract. Call our customer service department at the number on the back of your I.D. Card if you have questions.

Precertification Program

Program Description

You or the hospital must call us to receive certification for your hospital admission. Calling us will protect you from having to pay for unnecessary and noncovered stays. Call (800) 922-8778. **See page 17 for requirements for obtaining Mental Health admission benefits or page 22 for Substance Abuse Treatment admission benefits.**

Preadmission Review is our review to determine if your scheduled (non-emergency) Inpatient admission is Medically Necessary. Contact us two weeks prior to a scheduled Inpatient admission. Notify us if your admission or service date changes.

Admission Review is our review to determine whether your unscheduled Inpatient admission is necessary for:

- an emergency condition;
- a maternity condition or a newborn baby's condition that requires an extended hospital stay.

Contact us (within 48 hours or as soon as reasonably possible) after an emergency or maternity admission. Contact us (within 48 hours or as soon as reasonably possible) after the mother's discharge if the newborn stays in the hospital.

Continued Stay Review is our review to determine if your continued Inpatient care is necessary. If you choose to remain in Inpatient care longer than we deem appropriate, you may have to pay all charges for Inpatient care after the date we determined you could have left the Inpatient Facility.

Notes:

- A family member, Physician or Facility may make precertification calls for you.
- Call **(800) 922-8778** for Precertification Program reviews. Call **(800) 395-1356** for mental health or substance abuse treatment admissions.

Prior Approval Program

BCBSVT requires Prior Approval for certain services, drugs and supplies. **If you do not get approval in advance for these services, your care will not be covered. See your *Outline of Coverage* for the list of services that require Prior Approval.** Obtaining Prior Approval for these services ensures the procedures are diagnostically appropriate, medically necessary and cost effective.

To get Prior Approval your physician must send a letter with supporting documentation to BCBSVT. The medical staff at BCBSVT will review the information and respond in writing to you and to your doctor.

We do not allow benefits for services or supplies that are listed on your *Outline of Coverage* if you do not get approval in advance. In cases where Prior Approval is denied or not sought, you must pay the full cost of your care.

Case Management

Case Management is a program that offers you help in getting appropriate and effective

medical treatment. Our registered nurses are trained in case management and know your benefit plan. Your Nurse Case Manager will work with you, your family, your physician and other providers to evaluate your health care needs and coordinate services. Our goals are to achieve the best health outcome for you and to help you get the most out of your health care benefits.

The case management program is voluntary and available at no cost to eligible members. We may decide to provide benefits through this program for services we do not generally cover. The fact that we provide special benefits in one instance does not obligate us to do so again.

The BlueCard Program

When you obtain health care services outside the geographic area we serve, we coordinate claims processing with the out-of-area Blue Cross and Blue Shield plans through the BlueCard Program. The amount you pay for Covered services is usually calculated on the lower of:

- the actual billed charges for your Covered services; or
- the negotiated price that the local Blue Cross and/or Blue Shield Plan passes on to us.

Often, this "negotiated price" will consist of a simple discount. But sometimes it is an estimated final price that factors in expected settlements or other non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be a discount from billed charges that reflects average expected savings. The estimated or average price may be prospectively adjusted to correct for over- or underestimation of past prices.

In addition, laws in a small number of states require Blue Cross and/or Blue Shield Plans to use a basis for calculating your payment for Covered services that does not reflect the entire savings realized or expected to be realized on a particular claim. When you receive Covered health care services in those states, your required payment for these services will be calculated using their statutory methods.

Chapter Two
Covered Services

Ambulance Services

We provide benefits for transportation of the sick and injured:

- to a facility from the scene of an accident or medical Emergency; or
- between facilities (but not for the patient's or the Provider's preference).

We only cover Ambulance transportation to the nearest appropriate facility. We do not cover an Ambulance if a patient could have safely ridden in a private car, whether or not one was available.

Chiropractic Services

We provide benefits for care by a Chiropractor who:

- is in our Preferred Provider network;
- is working within the scope of his or her license; and
- treats you for a "neuromusculoskeletal" condition (that is, a condition of the bones, joints or muscles).

We provide benefits for:

- office visits, spinal manipulations and associated modalities;
- home, hospital or nursing home visits; or
- Diagnostic Services (e.g., labs and X-rays).

Requirements and conditions that apply to coverage for services by other Providers also apply to this coverage.

You must use a Preferred Provider and get Prior Approval from us for any visits after your 12th visit, or your care will not be covered. Please have your Provider write to Medical Services, Blue Cross and Blue Shield of Vermont, P.O. Box 186, Montpelier, VT 05601-0186 to get Prior Approval. He or she must send appropriate treatment plans.

We provide *no* chiropractic benefits for:

- treatment after the 12th visit if you don't get Prior Approval;
- services by a Nonpreferred Provider;
- treatment of any "visceral condition," that is a dysfunction of the abdominal or thoracic organs, or other condition that is not neuromusculoskeletal in nature;
- therapy for a Chronic condition when the therapeutic goals of a treatment plan have been achieved and no progress is apparent or expected to occur;
- supplies or Durable Medical Equipment;
- treatment of a Mental Health Condition;
- prescription or administration of drugs;
- obstetrical procedures including prenatal and postnatal care;
- Surgery; or
- any other procedure not listed as a covered chiropractic service.

Please remember that the general exclusions in Chapter Three also apply.

Dental Services

You must get Prior Approval from us for all dental services except wisdom teeth extractions or your care will not be covered. (See your *Outline of Coverage*.) We cover only the following dental services:

- treatment for accidental injury to the jaws, sound natural teeth, mouth or face within six months of an accident if the accident occurs on or after your membership effective date (in the event of an emergency, you must contact us as soon as possible afterward for approval of continued treatment);
- Surgery to correct gross deformity resulting from major disease or Surgery (within six months of the onset of disease or six months after Surgery);
- Surgical removal of bone-impacted teeth; and
- gingivectomy only for general or systemic conditions or conditions resulting from the effects of drugs.

We provide no benefits for:

- tooth implants (except for treatment of accidental injury within six months of the accident);
- care for periodontitis;
- repair or replacement of a damaged dental prosthesis;
- injury as a result of chewing or biting;
- pre- and post-operative dental care (we consider most pre- and post-operative visits part of the surgical benefit, so we do not provide additional benefits for these services);
- orthodontics (including orthodontics performed as an adjunct to orthognathic surgery);
- procedures performed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling); or
- dental care not specified above.

Please remember that the general exclusions in Chapter Three also apply.

Diabetes Services and Supplies

We provide benefits for services and supplies for treatment of diabetes. For example, we cover syringes, insulin, nutritional counseling, outpatient self-management training and education for people with diabetes. We provide these benefits subject to the same terms and conditions we use for other medical treatments. **We only cover nutritional counseling by Preferred nutritional counseling Providers. (See page 17.)**

Diagnostic Services

You must get Prior Approval for special radiology procedures (MRI, MRA, PET scans) and polysomnography (sleep studies) or your care will not be covered. (See page 8.)

We cover the following Diagnostic Services (tests to help find or treat a condition):

- imaging (radiology, X-rays, ultrasound and nuclear imaging);

- studies of the nature and cause of disease (laboratory and pathology tests);
- medical procedures (ECG and EEG);
- allergy testing (percutaneous, intracutaneous, patch and RAST testing);
- mammography; and
- hearing tests by an Audiologist if your doctor suspects you have a disease condition (see exclusion number 30 in General Exclusions).

Emergency Care

We cover Hospital services and supplies for treatment of an Emergency Medical Condition. To get emergency care benefits, you must show symptoms severe enough that a "prudent layperson" would believe that your health would be threatened without treatment. If you go to the emergency room when you could have safely received care somewhere else, **your care may not be Covered.**

Home Care

We cover the services of a Home Health Agency or Visiting Nurse Association that:

- performs skilled nursing procedures in your home;
- trains your family or other care-givers to perform necessary procedures in your home; or
- performs Physical, Occupational or Speech Therapy (please see page 22 for further information about Physical, Occupational or Speech Therapy benefits).

We also cover:

- services of a home health aide (for personal care only) when you are receiving skilled nursing or therapy services;
- other necessary services and supplies (except drugs and medications) furnished and billed by a Home Health Agency/Visiting Nurse Association; and
- home infusion therapy **(only if you get Prior Approval).**

We only cover Home Care services when your Physician:

- approves a home care plan of treatment for a reasonable period of time;
- includes a treatment plan in your medical record;
- certifies that the services are for Acute Care (not for Chronic Care); and
- re-certifies the treatment plan every 60 days.

Also, we only provide benefits if the patient, or a legally responsible individual, consents in writing to the home care treatment plan.

Private Duty Nursing

You must get Prior Approval for private duty nursing or your care will not be covered. (See page 8.)

We cover skilled nursing services by a private-duty nurse outside of a hospital, subject to these limitations:

- We don't cover private duty nursing services and Home Health Care Services provided at the same time.
- We limit benefits for private duty nursing to $2,000 per member per year.

Remember that the exclusions in Chapter Three also apply.

Home Care Exclusions

We do not provide home health care benefits for:

- Chronic care (see Definitions);
- homemaker services (except hospice care, as described below);
- Custodial Care;
- food or home-delivered meals; and
- drugs and medications.

Please also remember that general exclusions in Chapter Three also apply.

Hospice Care

We cover the following services provided by a Hospice Provider:

- up to two skilled nursing visits per day;
- up to 100 hours per month of personal care by a home health aide;
- up to 100 hours per month of homemaker services for house cleaning, cooking, etc.;
- up to five days or 120 hours of continuous care in your home;
- up to 72 hours each month of Respite Care;
- up to six social service visits before the patient's death and up to two bereavement visits after the patient's death to provide counseling and emotional support, assessment of social and emotional factors related to the patient's condition, assistance in resolving problems, assessment of financial resources, and use of available community resources; and
- other necessary services and supplies.

We only provide benefits if:

- a Physician certifies that the illness has a prognosis of six months life expectancy or less;
- the patient and the Physician consent to the Hospice care plan; and
- a primary care giver (family member or friend) will be in the home.

Hospital Charges

Note on Mental Health and Substance Abuse Treatment Services:

The description of services below does not apply to Inpatient or Outpatient Mental Health and Substance Abuse Treatment. The requirements for Mental Health benefits are listed on page 17. Requirements for Substance Abuse Treatment benefits are listed on page 22.

Inpatient Services

We cover charges made by a hospital or a Preferred Skilled Nursing Facility for Acute Care during an Inpatient stay. The Facility usually makes these charges for:

- room and board;
- "ancillary" services, such as tests done in the hospital; and
- supplies, including drugs given to you by the hospital or Skilled Nursing Facility during a Covered stay.

We cover either the day of admission or the day of discharge, but not both. Please see page 8 for precertification program requirements. You must call for Preadmission or Admission Review when you have an Inpatient stay.

This section explains benefits for charges by the hospital only. We also cover care by Physi-

cians and other Professionals while you are in the Hospital. See "Physicians' (and Other Professionals') Services" for a description of that coverage.

Outpatient Services

We also cover charges by the hospital when you are an Outpatient. You may, for example, go to the hospital for Diagnostic Services, infusion therapy or emergency care. Other sections of this Certificate may explain coverage for care you receive as an Outpatient. Please refer to the kind of treatment you need (for example, "Emergency Care" or "Therapy"). Also check your *Outline of Coverage* to see if you need Prior Approval for the service you need.

Maternity

Your hospital benefits cover your Inpatient maternity stay. (See "Hospital Charges" above for a description of your hospital benefits.) We also cover the following care by a Physician or other Professional during a woman's pregnancy:

- prenatal visits and other care;
- delivery of a baby;
- postnatal visits; and
- well-baby care and an initial hospital visit for the baby while you are an Inpatient.

We provide benefits for home delivery or delivery in a Facility when you use a Covered Provider. We provide benefits for services by certified nurse midwives (not lay or professional midwives) only if they are Preferred Providers.

Our Allowed Price for delivery of a baby includes all of the services listed above. This allowance is called a "global fee." If you change providers during your pregnancy, we will divide this fee appropriately. In addition to the services included in the global fee, we cover care for complications of pregnancy.

We cover newborns under this Contract for up to 31 days after birth. (Refer to Chapter Seven for information on how to continue coverage for your newborn past this period.)

Please see page 8 for requirements of the precertification program. You must call for Admission Review when you have a maternity stay.

Better Beginnings® Maternity Wellness Program

The *Better Beginnings* program helps our members and their babies get the best care before and after the baby's birth. If you join this program, we cover:

- up to three skilled nursing visits from a Home Health Agency in your home within 60 days of your discharge from the Hospital or within 60 days after delivery of your baby at home;
- up to nine hours of homemaker services from a Home Health Agency within 60 days after you are discharged from the Hospital or 60 days after delivery of your baby at home;
- up to $75 in reimbursement for approved childbirth classes; and
- educational materials provided by our nurse case managers.

To join the program, you must agree to participate in the *Better Beginnings* program and then:

- call customer service at the number on the back of your I.D. Card as soon as possible during your pregnancy (you get the most out of the *Better Beginnings* program when you contact us in the first three months of your pregnancy, but you may enroll any time during your pregnancy);
- complete a Health Risk Assessment Questionnaire; and
- attend regularly scheduled prenatal visits with a Provider.

To get reimbursement for childbirth classes, forward your receipt with a certificate of completion and a claim form, to Better Beginnings, P.O. Box 186, Montpelier, VT 05601-0186.

Note:

- We cover professional services of a Preferred Certified Nurse Midwife (but not a lay or professional midwife) or a Physician for home delivery of a baby.
- We may provide benefits through this program for services that we do not generally cover. (These services are described in your Better Beginnings packet.) The fact that we provide special benefits in one instance does not obligate us to do so again.
- Program options will be included in your first *Better Beginnings* packet.
- We offer the services of a Nurse Case Manager to members who would benefit from more support and monitoring.
- You do not have to pay Deductible or Coinsurance for skilled nursing and homemaker visits provided through the Better Beginnings Program.

Medical Equipment and Supplies

Durable Medical Equipment (DME)

You must get Prior Approval for continuous passive motion (CPM) equipment, TENS units, or Durable Medical Equipment with a purchase price over $1,000, or your DME will not be covered. (See page 8.)

We cover Durable Medical Equipment you purchase from a:

- Physician;
- occupational, physical or speech therapist; or
- Durable Medical Equipment supplier.

We provide benefits for the rental or purchase of Durable Medical Equipment. We reserve the right to determine whether rental or purchase of the equipment is more cost-effective and/or appropriate. The total rental benefits may not exceed our Allowed Price for the purchase of the equipment.

Supplies

We cover medical supplies such as needles and syringes and other supplies for treatment of diabetes, dressings for cancer or burns, catheters, colostomy bags and related supplies and oxygen, including equipment Medically Necessary for its administration.

Orthotics

You must get Prior Approval for orthotics or they will not be covered. (See page 8.) When you get Prior Approval, we provide benefits for molded, rigid or semi-rigid support de-

vices that restrict or eliminate motion of a weak or diseased body part.

Prosthetics

You must get Prior Approval for prosthetics or they will not be covered. (See page 8.) We provide benefits for the purchase, fitting, necessary adjustments, repairs and replacements of prosthetics. We cover a device (and related supplies) only when the device is surgically implanted or worn as anatomic supplement to replace:

- all or part of an absent body organ (including contiguous tissue and hair);
- the lens of an eye; or
- all or part of the function of a permanently inoperative, absent or malfunctioning body part.

The benefit covers prosthetic devices that are attached to (or inserted into) prosthetic shoes, and which replace a missing body part.

We only provide benefits for eyeglasses or contact lenses that replace the lens of an eye when the lens was not replaced at the time of surgery. We cover only:

- one set of accompanying eyeglasses or contact lenses for the original prescription; and
- one set for each new prescription.

Also, we provide benefits for dental prostheses only if required:

- in treatment of accidental injury (except injury as a result of chewing or biting); or
- to correct gross deformity resulting from major disease or Surgery.

Exclusions

We provide no benefits for:

- prosthetics or orthotics for which you have not received Prior Approval from us;
- dental appliances or dental prosthetics, except for treatment of temporomandibular joint syndrome or obstructive sleep apnea;
- shoe insert orthotics, lifts, arch supports or special shoes not attached to a brace;
- custom-made or custom-molded knee braces (custom-fitted, "off-the-shelf" braces are covered);
- dynamic splinting, continuous passive motion equipment (unless you get Prior Approval) and programmable or variable resistance devices;
- any treatment, durable medical equipment, supplies or accessories intended principally for participation in sports or recreational activities or for personal comfort or convenience;
- repair or replacement of dental appliances or dental prosthetics; and
- eyeglasses or contact lenses, except when necessary to replace the lens of the eye (and the lens was not replaced at the time of surgery).

Also refer to “General Exclusions” in Chapter Three.

Notes:

- DME Providers can be Preferred Providers, like some Physicians are. You may pay less if you use a Preferred Provider.
- To be sure your item meets our definition of Durable Medical Equipment, you may call our customer service department before purchasing a DME item.

Mental Health Care

You must use a Network Provider and get Prior Approval for all Mental Health Services or your care will not be covered. We provide benefits for Outpatient Mental Health Services including:

- individual and group Outpatient psychotherapy;
- family and couples therapy;
- psychological testing when integral to treatment; and
- psychotherapeutic programs directed toward improving compliance with prescribed medical treatment regimens for such Chronic conditions as diabetes, hypertension, ischemic heart disease and emphysema.

We provide benefits for Inpatient Mental Health Care services including:

- hospitalization;
- Partial Hospital, day treatment;
- Residential Treatment Program; and
- Intensive Outpatient Programs.

We provide benefits for Mental Health Services only if:

- you obtain Prior Approval for all Mental Health Services by calling the number below; and
- you receive care from Network Mental Health Providers.

If you are outside Vermont and need mental health services, the above guidelines still apply. The phone number for our Mental Health Network is **(800) 395-1356.** When you call, you can get the name of a Provider in our mental health network.

Mental Health Exclusions

The Plan provides no Mental Health benefits for:

- services from Mental Health Providers that are not members of our mental health Network;
- treatment we do not approve in advance.
- Chronic care (see Definitions);
- nontraditional, alternative therapies such as eye movement desensitization, Rubenfeld Synergy, energy polarity therapy and somatization therapy, that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- services, including residential programs and adventure-based activities, that focus on education, socialization, delinquency or Custodial Care; and
- biofeedback, pain management, stress reduction classes and pastoral counseling.

Remember that the general exclusions in Chapter Three also apply.

Nutritional Counseling

We cover up to three outpatient nutritional counseling visits each calendar year. Nutritional counseling for treatment of diabetes does not count toward the three visit limit.

Nutritional counseling must be provided by one of the following Preferred Providers or your care will not be covered:

- Medical Doctor (M.D.);
- Doctor of Osteopathy (D.O.);
- registered dietician (R.D.);
- nutritionist licensed in Vermont;
- certified diabetic educator (C.D.E.); or

- nurse practitioner.

Optometry Services

We cover services by an Optometrist only when he or she finds or reasonably suspects a disease condition and refers you to a Physician for treatment of that condition. We cover your visit to an Optometrist in the same way we cover visits to Physicians performing Covered eye care.

We don't cover eyeglasses, contact lenses or any examination for the prescription, fitting or determination of need for eyeglasses or lenses unless you need them to replace the lens of the eye and the lens was not replaced at the time of surgery (see Prosthetics, page 16).

If you need lenses to replace the lens of the eye, we will cover only one pair of lenses per prescription.

Physician and Professional Services

After you read this section, please check your *Outline of Coverage* to see if your service requires Prior Approval.

Inpatient Medical Services

We cover services by a Physician or Professional Provider who sees you when you are an Inpatient in a Hospital or Skilled Nursing Facility. In a General Hospital, these services may include:

- Surgery (see below);
- services of an assistant surgeon when necessary;
- anesthesia services for Covered procedures;
- intensive care; or
- other specialty care when you need it.

Notes on Surgery:

You must get Prior Approval for plastic/Cosmetic or Reconstructive Surgery or your care will not be covered. (See page 8.) Please note that Surgery benefits include Reconstructive Surgery that is not just plastic/Cosmetic. (Please see the definitions of Reconstructive and Cosmetic.) For *example,* we cover:

- reconstruction of a breast after breast Surgery;
- Surgery and Reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses (which we cover under "Medical Equipment and Supplies" on page 15) and treatment of physical complications resulting from breast Surgery.

We cover sterilization procedures even though they are not Medically Necessary.

We limit Surgery benefits as follows:

- We cover only one attempt at reversal of sterilization.
- We make global payments for some surgeries and other procedures. This means that we pay your Professional Provider one payment for all office visits and other care that is related to the Surgery.
- We may limit the number of visits we cover by the same Provider in the same day.
- If you have several surgeries at the same time, we may not pay a full allowance for

each one. If you have questions about the way we determine our Allowed Price for Surgery, please call customer service at the number on the back of your I.D. Card.
- We exclude many types of Cosmetic Surgery (see exclusions in Chapter Three).

Note:

You will find a description of benefits for services by some Physicians, Professionals and Other Providers in other sections of this Certificate. For example, Mental Health Providers' services appear in the "Mental Health Care" section. Limitations may apply, so please read each section of this booklet carefully.

Office Visits

You pay a Visit Fee each time you have an office visit. (See page 6.) This office visit benefit covers:

- visits to a Physician's office for routine or preventive care;
- a Physician's visit to your home or skilled nursing facility;
- emergency room Physician;
- allergy injections;
- consultations;
- second opinions;
- covered immunizations;
- Well-baby and Well-child care; and
- approved outpatient mental health and substance abuse visits to Network Providers (see page 17 for Mental Health Care guidelines or page 22 for Substance Abuse treatment guidelines).

Examples of care for which you must pay Deductible and Coinsurance instead of your Visit Fee include:

- Diagnostic Services performed during an office visit (X-rays, labs, etc.);
- injections other than immunizations and allergy shots;
- outpatient surgery (see the next section);
- chemotherapy and infusion therapy (see page 22 for coverage); and
- prenatal and postnatal visits, and preoperative and postoperative visits, which fall under the global fee we pay Providers for your delivery or surgery.

We do not cover:

- bulk immunizations (those provided to a group of people) unless you get Prior Approval; or
- immunizations mandated by law to be provided by an employer.

Please also refer to general exclusions in Chapter Three.

Outpatient Medical Services

We cover care you receive from a Physician or Professional when you are not in the hospital. These visits include:

- Surgery (see notes on page 18);
- services of an assistant surgeon when necessary;
- anesthesia services for Covered procedures.

Note:

You will find a description of benefits for services by some Physicians, Professionals and Other Providers in other sections of this Certificate. For example, mental health Providers' services appear in the Mental Health Care section. Limitations may apply, so please read each section of this booklet carefully.

Prescription Drugs

We cover most Prescription Drugs (including contraceptives and contraceptive devices) if the Food and Drug Administration approves them for the treatment of your condition and you purchase them from a licensed pharmacy. We also cover injectable insulin, needles and syringes. We don't cover drugs and devices that do not require a prescription, even if your doctor prescribes or recommends them.

You may have a rider that replaces this section. If so, you may have to use a network pharmacy to get coverage. Check your *Outline of Coverage* to see if it lists a Prescription Drug Rider as one of your Contract documents.

We limit benefits for:

- prescribed fertility drugs to a four-month supply per calendar year; and
- prescribed smoking cessation drugs to a three-month supply per calendar year.

Limitations

We only provide benefits for pharmacological treatment of obesity when you get Prior Approval and your Body Mass Index (BMI) is over 30 or your BMI is over 27 with co-morbidities.

You must get Prior Approval for the following prescription drugs or your drugs will not be covered:

- Growth Hormone Replacement Therapy
  - Protropin
  - Nutropin
  - Genotropin
  - Humatrope
  - Serostim
  - Saizen
  - Norditropin
- Infertility Medications
  - Fertinex, Follistim, Gonal-F
  - GnRHa, Lupron, Synarel
  - Antagon, Cetrotide
  - Ovidrel, Pregnyl, Profasi, Novarel
  - Pergonal, Repronex, Humegon
- Red Blood Cell Stimulating Medications
  - Procrit/Epogen (erythropoietin)
- Low Molecular Weight Heparin Anticoagulants
  - Lovenox (enoxaparin)
  - Fragmin
  - Innohep
  - LMW heparinoids - Orgaran
- Botox (botulinum toxin)
- Zyvox
- Temodar
- Kineret
- Gleevec
- Anti-obesity Medications
  - Meridia
  - Xenical
- Primary Pulmonary Hypertension Therapy
  - Flolan
  - Tracleer
- Medications without an National Drug Code (NDC) number; and
- drugs approved for sale on the U.S. market by the Food and Drug Administration less than 12 months.

To get Prior Approval for your prescription drug, your provider must write to our medical services department with the following information:

- your name;
- your diagnosis;
- your I.D. number;
- clinical information explaining the medical necessity for the medication; and
- the expected frequency and duration of the medication.

The list of drugs that need Prior Approval changes from time to time. We will inform you of changes using newsletters and other mailings. Check with your doctor or visit our website at www.bcbsvt.com to see if a specific drug needs Prior Approval. You may also call our customer service department at the number on the back of your I.D. card.

Exclusions

We provide no prescription drug benefits for:

- refills beyond one year from the original prescription date;
- prescriptions greater than 90 days in supply;
- fertility drugs prescribed as treatment leading to, or in connection with, artificial insemination, intrauterine insemination, in-vitro fertilization, embryo transplantation or gamete intrafallopian transfer (GIFT);
- devices of any type other than prescription contraceptives, even though such devices may require a prescription order (including, but not limited to: Durable Medical Equipment, prosthetic devices, appliances and supports);
- any drug considered to be Investigational by the Food and Drug Administration or by us;
- vitamins, except those which, by law, require a Prescription;
- drugs and devices that do not require a prescription (except insulin), even if your doctor prescribes or recommends them; and
- nutritional formulae, except for up to $2,500 per year for "medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or those administered through a feeding tube.

Narcotics and antibiotics are limited to a 30-day supply.

Rehabilitation Services

You must get Prior Approval for Rehabilitation services or your care will not be covered. We cover Inpatient care for an Acute condition in Physical Rehabilitation Facility in our Preferred Provider Network. Your care must meet the following criteria:

- The attending Physician must certify that services of a Physical Rehabilitation Facility are required and are the most appropriate level of care for the condition being treated. The Physician must recertify every 30 days thereafter that the services are required and appropriate, and that significant progress is being made by the member.
- **We cover care only by a Preferred cardiac rehabilitation Provider to treat a condition requiring Acute Care.** We cover up to three supervised exercise sessions per week for up to a total of 18 sessions for each Acute cardiac event. You

must get Prior Approval from us for cardiac rehabilitation. Have your Provider write to us at Medical Services, BCBSVT, P.O. Box 186, Montpelier, VT 05601-0186. He or she must provide a treatment plan.

Chronic Care, cognitive retraining and educational programs are not Covered Rehabilitation services. Please remember that the general exclusions in Chapter Three also apply.

Substance Abuse Services

You must use a Network Provider and get Prior Approval for all Substance Abuse Treatment services or your care will not be covered. We provide benefits for the following Substance Abuse treatment services:

- detoxification;
- Outpatient rehabilitation (including services for the patient's family when necessary); and
- Inpatient rehabilitation.

We provide benefits only if:

- you obtain Prior Approval for all Substance Abuse Treatment Services; and
- you receive care from Network Substance Abuse Treatment Providers.

If you are outside Vermont and need substance abuse treatment, the above guidelines still apply. The phone number for our Substance Abuse Network is **1-800-395-1356.**

We provide no Substance Abuse benefits for:

- Chronic care (see Definitions);
- treatment that we do not approve in advance; and
- services from Substance Abuse Counselors or Substance Abuse Facilities that are not members of our Substance Abuse Network.

Remember that the general exclusions in Chapter Three also apply.

Therapy

We cover therapy services provided by an eligible Hospital, Skilled Nursing Facility or Home Health Agency/Visiting Nurse Association or included on a bill from one of those Providers. We also cover the services of a registered physical therapist in an office or home setting. Therapy services could include the following:

- radiation therapy;
- chemotherapy;
- dialysis treatment;
- Physical Therapy;
- Occupational and Speech Therapy; and
- infusion therapy.

We cover Occupational, Physical and Speech Therapy only:

- for Physical Therapy services that require constant attendance of a registered physical therapist;
- for up to 30 Outpatient sessions combined per calendar year or up to six months of therapy after initiation for a particular episode (whichever comes first); and
- if you can expect to show measurable improvement within six months of the episode.

You must get Prior Approval for home infusion therapy or your treatment will not be

covered. We provide benefits for home infusion therapy only if:

- your Physician prescribes a home infusion therapy regimen;
- you use services from a home infusion therapy Provider in our Preferred Provider Network; and
- you get Prior Approval.

We provide no benefits for a Provider to administer therapy when the patient or an alternate caregiver can be trained to do so.

Please remember that general exclusions in Chapter Three also apply.

Transplant Services

You must get Prior Approval for transplant services or your care will not be covered. We cover organ and bone marrow transplants, including benefits for a live donor's related medical expenses, when we cover the recipient. We also provide up to $25,000 in benefits per organ transplant and up to $20,000 in benefits per bone marrow transplant for the following related transplant expenses:

- search for a donor;
- surgical removal of an organ from a deceased donor; and
- storage and transportation costs for the organ or bone marrow.

We provide benefits only if you obtain Prior Approval. We reserve the right to review all requests for Prior Approval based on:

- the patient's medical condition;
- the qualifications of the Physicians performing the transplant procedure; and
- the qualifications of the Facility hosting the transplant procedure.

Benefits for Live Donors

We pay benefits to live donors as follows:

- if we cover both the recipient and the donor, each receives benefits under his or her own Contract;
- if we cover the recipient, but not the donor, both receive benefits under the recipient's Contract (benefits available to the recipient will be paid first);
- no benefits are available if we cover the donor, but not the recipient;
- we cover up to $65,000 in surgical, storage and transportation expenses incurred by a live donor for each covered organ transplant procedure completed;
- we cover only costs directly related to the organ donation, including costs resulting from complications of the donor's surgery;
- such costs must be incurred within 120 days from the date of the donor's surgery.

In the event the covered organ transplant procedure is not completed, we cover the surgical storage and transportation costs of donation by a living donor only if the covered organ transplant procedure was scheduled to occur within 24 hours of the donor's surgery.

Such covered donor expense will be reimbursed subject to the same Deductibles, Co-payments and Coinsurance rates as would apply to the expenses if subject to the terms of the transplant recipient's Contract.

Time Period

This Transplant section covers recipient expenses directly related to the transplant procedures when they are incurred:

- from 30 days before the procedure to 365 days after the procedure for bone marrow transplants; or
- from five days before the procedure to 365 days after the procedure for all other transplants.

Any benefits provided within this time period are subject to the lifetime transplant benefit maximum listed on your *Outline of Coverage*. Benefits provided within this time period for transplant-related office visits, labs or Prescription Drugs are subject to the terms and conditions in the other sections of your Contract, including Visit Fees and the General Exclusions in Chapter Three.

Lifetime Transplant Maximum

We provide benefits for all transplant services and supplies within the time period specified above up to a lifetime transplant maximum that is listed on your *Outline of Coverage*. This maximum transplant benefit is separate from your other lifetime benefit maximums for other services and supplies Covered under your Contract.

Exclusions

We provide no benefits for the purchase price of any organ or bone marrow that is sold rather than donated. Please remember that general exclusions in Chapter Three also apply.

Chapter Three
General Exclusions

Note: Subject to your rights under this Contract and the law that allows you to appeal a denial of benefits, we have the authority to interpret and apply the terms of this Contract and to determine whether and to what extent you have coverage for a requested service, even when a Provider has prescribed or recommended the service.

We pay benefits only for Covered services and supplies described in your Contract. This Certificate and any of your Riders or Endorsements may contain specific exclusions. Additionally, we do not cover:

1. Services or supplies that must be Covered by a prior health plan as extended benefits.
2. Services or supplies for which you would have no legal obligation to pay if you did not have your Contract or similar coverage.
3. Services or supplies for which there is no charge.
4. Services or supplies paid directly or indirectly by a local, state or federal government agency, except as otherwise provided by law.
5. Services or supplies you require as a result of your commission or attempt to commit a felony, or your engagement in an illegal occupation.
6. Services or supplies in excess of the limitations or maximums set forth in your Contract.
7. Services or supplies we determine are not Medically Necessary.
8. Services or supplies that we determine are Investigational, mainly for research purposes or Experimental in nature.
9. Services or supplies that are not provided in accordance with accepted professional medical standards in the United States.
10. Acupuncture, acupressure or massage therapy; hypnotherapy, rolfing, homeopathic or naturopathic remedies.
11. Alpha-Stim® Units.
12. Automatic ambulatory home blood pressure monitoring.
13. Biofeedback or other forms of self-care or self-help training.
14. Whole blood, blood components, costs associated with the storage of blood, testing of blood the patient donates for his or her own use (even if the blood is used), transfusion services for blood and blood components the patient donates for his or her own use in the absence of a covered surgical procedure. (This exclusion does not apply to blood derivatives and transfusion services for whole blood, blood components and blood derivatives.)
15. Chronic (see Definitions) care.
16. (Routine) circumcision.
17. Clinical ecology, environmental medicine, Inpatient confinement for environmental change or similar treatment.

18. Cognitive retraining and educational programs, except for diabetes education.

19. Communication devices and communication augmentation devices.

20. Consultations except when they occur between Providers and the Providers attach a written report to the patient's medical record.

21. Correction of near- or farsighted conditions or aphakia (where the lens of the eye is missing congenitally or accidentally or has been surgically removed, as with cataracts) by means of corneal microsurgery or "laser Surgery," such as keratomileusis, keratophakia, and radial keratotomy and all related services.

22. Cosmetic/plastic procedures and supplies that are not Reconstructive.

23. Custodial Care, domiciliary care or rest cures.

24. Dental care, services and supplies and oral Surgery, unless specifically provided by your Contract; procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling).

25. Drugs that do not require a prescription, except insulin.

26. Eye exercises or visual training.

27. Eyeglasses, contact lenses or any examination for the prescription, fitting or determination of need for eyeglasses or lenses unless you need them to replace the lens of the eye and the lens wasn't replaced at the time of the surgery.

28. Educational evaluation or therapy or treatment of developmental delays, except for treatment of diabetes, such as medical nutrition therapy by Preferred Providers.

29. Foot care or supplies that are palliative or Cosmetic in nature, including supportive devices and treatment for bunions (except capsular or bone Surgery), flat-foot conditions, subluxations of the foot, corns, callouses, toenails, fallen arches, weak feet, Chronic foot strain, and symptomatic complaints of the feet. This exclusion does not apply to coverage for necessary foot care for people with diabetes.

30. Hearing aids or examinations for the prescription or fitting of hearing aids.

31. Home or automobile modifications like air conditioners, HEPA filters, humidifiers, stair glides, elevators, lifts, motorized scooters, furniture or "barrier-free" construction, even if prescribed by a Provider.

32. Illnesses or injuries which are:
- a result of an act of war (declared or undeclared); or
- sustained in active military service (Note: upon receipt of written request, the Plan will suspend coverage for the military member and make a refund on a pro rata basis for subscription rates paid for the time period the member is in active military service).

33. Mandated treatment, including court-ordered treatment, unless such treatment is Medically Necessary, ordered by a Physician and Covered under your Contract.

34. Nonmedical charges, such as:
- a penalty for failure to keep a scheduled visit; or
- fees for completion of a claim form.

35. Nutritional counseling beyond three visits per calendar year. (This exclusion does not apply to nutritional counseling for treatment of diabetes.)

36. Nutritional formulae, except for up to $2,500 per year for "medical foods" prescribed for the Medically Necessary treatment of an inherited metabolic disease or those administered through a feeding tube.

37. Orthodontics, including orthodontics performed as adjunct to orthognathic surgery or in connection with accidental injury.

38. Orthotics for which you have not received Prior Approval.

39. Pain management programs.

40. Personal hygiene items.

41. Personal service or comfort items.

42. Photography services, photographic supplies or film development supplies or services (for example, external ocular photography or photography of moles to monitor changes).

43. Physical fitness equipment, braces and devices intended primarily for use with sports or physical activities other than activities of daily living (e.g. knee braces for skiing, running or hiking); weight loss programs and health club memberships.

44. Services or supplies that should be or should have been covered as part of an evaluation for or inclusion in a Child's Individualized Education Plan (IEP) or other educational program.

45. Support therapies, including pastoral counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy, smoking cessation therapy, stress management, wilderness programs, adventure therapy and bright light therapy.

46. More than one attempt at reversal of sterilization.

47. Telephone consultations (between Provider and patient).

48. TENS (transcutaneous electrical nerve stimulation) units except with written Prior Approval from us. (Note: We will not approve TENS units to treat headache, pelvic or deep abdominal pain or jaw pain.)

49. Therapy services provided as a part of Chronic pain control, developmental, pulmonary or other form of rehabilitation, except:

- treatment of diabetes by an approved, Preferred Provider; or
- upon prior written approval by the Plan.

50. Travel (other than Ambulance transport), even if prescribed by a Physician.

51. Evaluation and treatment (including medications) leading to, or in connection with, artificial insemination (intravaginal, intracervical and intrauterine insemination), in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT). This exclusion does not apply to the evaluation to determine if and why the couple is infertile.

52. Treatment and medications leading to, or in connection with, transsexual Surgery.

53. Non-prescription treatment of obesity, except surgical treatment when:

- your Physician determines that your Body Mass Index is over 40 (according to Table 1 in the "Methods for Voluntary Weight Loss and Control"

booklet by the National Institute of Health Technology Assessment Conference Statement of March 1992);

- you have other medical conditions that could be significantly and adversely affected by this degree of obesity.

54. Treatment for willfully uncooperative or intractable patients.

55. Work-related illnesses or injuries (or those which you claim to be work-related, until otherwise finally adjudicated), provided such illnesses or injuries are covered by workers' compensation or should be so covered. (This provision shall not be deemed to require, as a condition to obtaining coverage, an individual, such as a sole proprietor or owner partners, to obtain workers' compensation if he or she is not under a legal obligation to be so covered.)

Also, your Contract does not Cover services or supplies prescribed or provided by a:

56. Provider that we do not approve for the given service or who is not defined in our "Definitions" section as a Provider.

57. Professional who provides services as part of his or her education or training program.

58. Yourself or a member of your immediate family.

59. Veterans Administration Facility treating a service-connected disability.

60. Nonpreferred Provider if we require use of a Preferred Provider as a condition for coverage under this Certificate.

61. Non-Network Provider if we require Network Participation as a condition for coverage under this certificate.

Chapter Four
Pre-existing Conditions

We define Pre-existing Condition as a condition for which you have sought medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment has been recommended during the six months before you became covered under this Contract.

Waiting Period

We do not provide benefits for services related to Pre-existing Conditions until nine months after the effective date of this coverage.

Exceptions

Emergencies

We provide benefits for Pre-existing Conditions within the nine-month waiting period when you are treated on an emergency basis, as documented by medical records and as determined by us.

Maternity

Maternity coverage has no waiting periods. You may use services regardless of how long you have had this coverage.

Previous Coverage

If you had previous coverage with us or any other carrier, we will credit all or part of your waiting periods for Pre-existing Conditions:

- if you have not had more than a "90-day break in coverage" (as defined by law) before obtaining this coverage; and
- if your previous coverage had substantially the same Covered services as this coverage.

We will credit your waiting periods to the extent that you met all or part of the previous carrier's waiting periods. (For example, if you met six months of the waiting period for your previous coverage, you will get six months of credit toward the waiting period for this coverage.)

Children Born or Adopted After the Effective Date

Coverage for Children born, adopted, or placed for adoption after the Subscriber's effective date is not subject to Pre-existing Condition limitations. They must, however, become Covered within 94 days after they are first eligible for coverage under your Contract. Dependents who do not become Covered under your Contract during these 94 days must fulfill their own waiting periods for Pre-existing Conditions.

Waiver

If your group purchases a waiver of waiting periods, you do not have to fulfill waiting periods in this section. In this case, a *Waiver of Waiting Periods* document should be included in

your Contract and be listed on your *Outline of Coverage*.

Credit for Subscriber Waiting Periods

Dependents who become covered under your Contract during their initial eligibility period (see Adding Dependents in Chapter Seven) are not required to fulfill waiting periods for pre-existing conditions to the extent that the Subscriber has fulfilled his or her waiting periods. Dependents who do not become covered under your Contract during their period of initial eligibility must fulfill their own waiting periods unless other exceptions apply.

Chapter Five
Claims

Remember, when you contact a Provider, you must:

- tell the Provider you have coverage with Blue Cross and Blue Shield of Vermont; and
- give information about all other health coverage you have.

Claim Submission

We must receive your claim within 12 months after you receive a service or supply. Your claim must include all information necessary for us to administer your benefits.

Network and Preferred Providers will usually submit claims on your behalf if this is your primary coverage. (See "Other Party Liability" on page 36.) If you receive services from a Nonpreferred Provider, you must file your own claims.

Release of Information

We may need records, copies of records, verbal statements or other information to administer your benefits. By accepting your Contract, you give us the right to obtain, from any source, any information we need for use in connection with policy administration, subject to applicable state and federal laws. We also have the right to obtain information to perform utilization review and care management studies and analyses of benefit programs.

Our approval of your benefits is conditional upon your furnishing us with such information, even if we provide benefits before we obtain the information. In order to avoid duplicate payments, we may furnish information to other entities who provide similar benefits, unless otherwise prohibited by law.

Payment of Benefits

We pay Network and Vermont Preferred Providers directly. We reserve the right to pay out-of-state Preferred Providers directly. We usually pay you directly for services received from Nonpreferred Providers. We reserve the right, however, to pay you or your Nonpreferred Providers directly.

Your rights under your Contract are personal. This means that you may not assign your benefit rights to any other party, including a Nonpreferred Provider. We may refuse to honor any benefit assignment presented to us.

For information on how we determine your benefit amount, see Chapter One.

Payment in Error

If we pay benefits to you incorrectly, we require you to repay us any overpayment. If this occurs, we will send you a written notice re-

questing a refund. If we pay your Provider incorrectly, we reserve the right to seek reimbursement from you or your Provider. In either case, we may reduce or withhold future benefits to recover incorrect payments.

Regardless of whether we seek recovery, an erroneous payment on one occasion will not obligate us to provide benefits on another occasion.

When You Have a Complaint

The following sections explain what to do when you don't agree with one of our decisions or when you have a complaint about our service or a doctor's care. Instructions to follow when you have a complaint about Mental Health or Substance Abuse Treatment are on page 34. You may get assistance in any of the following ways. At any time, you may call the Vermont Division of Health Care Administration for help at (800) 631-7788 or (802) 828-2900.

Complaint (or Inquiry) to Customer Service

Our customer service team can solve most problems. We encourage you to contact customer service before filing an appeal (below) because it may save you time. Contact us at the number on the back of your I.D. card and we will review your complaint. If you wish, another person for whom you have completed an *Authorization to Release Information Form*—perhaps a provider—may call for you. Please have your I.D. Card handy when you call.

You may also write to:
Blue Cross and Blue Shield of Vermont
Customer Service
P.O. Box 186
Montpelier VT 05601-0186

We resolve complaints as soon as possible. You can make a medical complaint if you have problems with the medical care or advice that you got from your doctor. You may also make a non-medical complaint. Non-medical complaints might be about:

- Plan services
- Plan rules
- Waiting times to get appointments
- After-hours access to your doctor
- The service at the doctor's office

Claim Appeal

You may file an appeal after a customer service review (above) or without one. You have the right to obtain copies of all information related to your appeal. (We suggest you make a complaint to customer service first. This may save you time.) If your appeal is related to Emergency or Urgent Services, you may submit your appeal verbally. All other appeals should be submitted in writing. If needed, we will help you with your appeal. Call customer service at the number on the back of your I.D. card for help.

Send your appeal to:
Blue Cross and Blue Shield of Vermont
Claim Appeal
P.O. Box 186
Montpelier VT 05601-0186

Please be specific about your appeal. If it involves a decision to deny coverage for services, deny eligibility, or reduce your benefits, call or

write within 180 calendar days of when you receive notice of the denial or reduction in benefits. Once you make a formal appeal, an impartial reviewer(s) will conduct a review to attempt to resolve it. If it is about a decision to deny or reduce benefits, we will see if we should pay your claim.

For an appeal related to medical care not yet rendered, we will complete the review and send you notice of our decision within 30 calendar days of receiving your request for review. For appeals related to medical care you have already received, we will complete the review and send you notice of our decision within 60 calendar days of receiving your request for review. If your complaint involves a request for Emergency or Urgent Services, we will review it and notify you of our decision within 72 hours of receiving your request. For reviews not relating to medical care, we will notify you of our decision within 30 days of receiving your request.

Notes:

- The State of Vermont has a Health Care Ombudsman's office. If you have a problem with your Plan, this office may be able to help. Call (800) 917-7787 or (802) 828-2316.
- By accepting your Contract, you agree to seek a decision of the Claim Appeal Reviewer before taking any judicial action. After you receive our decision, you may choose to pursue a voluntary second level of appeal (below) or, in certain circumstances, you may request an independent review with the State of Vermont by calling (800) 631-7788 or (802) 828-2900.
- Your plan may be subject to ERISA. If you are not satisfied with the outcome of the internal-appeal process, and your plan is subject to ERISA, you may have the right to bring legal action under section 502(a) of ERISA. Consult your benefit administrator to determine whether this applies to you. You are not required to pursue the voluntary second-level of appeal prior to bringing legal action. You are not required to submit your claim to the State of Vermont external appeal process prior to filing a suit under section 502(a) of ERISA.
- If you choose to take advantage of our voluntary second level of appeal (below) and are still not satisfied, you will have the right to file an external appeal with the State of Vermont and/or file suit under ERISA (if applicable) as described above after receiving the second-level decision.

Voluntary Second-Level Appeal

If you are not satisfied with the outcome of the First-Level Appeal, you may file a Second-Level Appeal. The second-level appeal is voluntary and is offered at no cost to you. You may also, in certain circumstances, request an external appeal with the State of Vermont by calling (800) 631-7788 or (802) 828-2900.

If you choose to file a Second-Level Appeal, you must do so within 90 days after you receive our appeal decision. If your appeal involves a request for Emergency or Urgent Services, you may submit your appeal verbally. All other appeals should be submitted in writing. If needed, we will help you with your appeal. Give as much information as you can when filing your appeal. Mail your appeal to:

Blue Cross and Blue Shield of Vermont
Voluntary Second-Level Appeal
P.O. Box 186
Montpelier VT 05601-0186

A different reviewer(s) will conduct a Second-Level review. You have the right to obtain copies of all information related to your appeal. You, or your representative for whom you have completed an *Authorization to Release Information Form*, also have the right to meet with the reviewer(s) before we make our final decision. If you are not able to participate by phone, we will make arrangements for you to participate in person. If your appeal involves a request for Emergency or Urgent Services, we will review it and notify you of our decision within two calendar days of receiving your request for appeal. For all other reviews, we will notify you of our decision within 30 days of receiving your request for appeal.

Note:

If you do not take advantage of the voluntary second level of appeal, the Plan waives its right to assert that you failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to the voluntary second level of appeal.

If you choose to take advantage of the voluntary second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the voluntary appeal is pending.

Mental Health and Substance Abuse Complaints (or Inquiry)

Mental health and substance abuse complaints (or inquiries) are handled by Merit Behavioral Care (MBC), an affiliate of Magellan Behavioral Health.

If you have a complaint about mental health or substance abuse care that was denied, call MBC's customer service department at (800) 395-1356. Our customer service team can solve most problems. If you wish, you can ask someone else for whom you have completed an *Authorization to Release Information Form* —perhaps your provider—to call for you. You may also file an appeal. (See below.)

Mental Health and Substance Abuse Claim Appeal

Mental health and substance abuse appeals are handled by Merit Behavioral Care (MBC), an affiliate of Magellan Behavioral Health.

You may file an appeal after a customer service complaint (described above). Or you may file an appeal right away. (We suggest you make a complaint to customer service first. This may save you time.) You have the right to obtain copies of all information related to your appeal. If you have an Emergency Medical Condition, we will notify you of our decision within 24 hours of receiving your request. On other appeals about mental health or substance abuse health care, we will send you notice of our decision in writing within 10 calendar days of receiving your request. If your appeal is about service (not actual health care), we will resolve it within 30 calendar days of receiving your request.

You must submit your appeal within 180 days of receiving our denial. You may submit an appeal in writing or by phone. Send written appeals to:

Merit Behavioral Care Corporation

110 Kimball Avenue, Suite 110
South Burlington, Vermont 05403

Or call (800) 395-1356 to submit your appeal by phone or for help submitting your appeal.

Note:

The State of Vermont has a Health Care Ombudsman's office. If you have a problem with your Plan, this office may be able to help. Call (800) 917-7787 or (802) 828-2316.

By accepting your Contract, you agree to seek a decision of the Claim Appeal Reviewer before taking any judicial action. After you receive our decision, you may choose to pursue a voluntary second level of appeal (below) or, in certain circumstances, you may request an external appeal with the State of Vermont by calling (800) 631-7788 or (802) 828-2900.

Appeal of First-Level Decision

You can have a second committee review your appeal if you aren't satisfied with the first decision. You have the right to obtain copies of all information related to your appeal. You, or your representative, also have the right to participate by phone. If you are not able to participate by phone, we will make arrangements for you to participate in person. To have this review, write to:

Blue Cross and Blue Shield of Vermont
Mental Health Second-Level Appeals
P.O. Box 186
Montpelier, VT 05601-0186

If you have an Emergency Medical Condition, we will notify you of our decision on your appeal within 24 hours. For all other appeals about health care, we will send you our decision within 30 calendar days of receiving your request.

Independent Review

Are you dissatisfied with either of our review committees' decisions? After the first review, you have the right to ask the state's Independent Panel of Mental Health Providers to review your case if it involves a denial of services because we think they are not medically necessary. The panel is not connected to BCBSVT. Or, if you choose to take advantage of our second level of review, and are still not satisfied, you can call the Independent Panel at that time and ask for a review. For more information about the Independent Panel, or to ask for a review, call (800) 631-7788 or (802) 828-2900.

Vermont's Mental Health Law

Vermont has a law that makes mental health and substance abuse treatment benefits equal to those for other physical problems. Your benefits comply with this law. For a brochure that describes how this law affects you, call (800) 395-1356.

When You Have to Pay

If your appeal is denied, you must pay for services we didn't cover. Make your payment to your provider.

Chapter Six
Other Party Liability

This Chapter gives us the right to prevent duplicate payments for a service that would exceed the amount of total allowable expenses for the service. It applies, for instance, when a person covered under your Contract also receives benefits, or is entitled to receive benefits as a result of any other health coverage or insurance. *Remember, you must disclose information about all other coverage to us.*

Coordination of Benefits

This Chapter applies when you are entitled to benefits or recovery under your Contract and also under another health plan or insurance policy that provides benefits for some or all of the same expenses as this one does. (For the purposes of this Chapter, we'll call the other party a "payer.")

We may reduce your benefits under your Contract so that the sum of the reduced benefits and all benefits payable for Covered services under another health plan or insurance policy does not exceed the total charges for Covered services.

Although we call the other plan or policy a "payer," we coordinate benefits based on coverage, not actual payment. Therefore, we treat the following benefits as "payment" from another payer:

- any benefits that would be payable if you made a claim (even if you don't); and/or
- benefits in the form of services.

When two payers coordinate benefits, one becomes "primary" and one becomes "secondary." The primary payer considers the claim first and makes its benefit determination. The secondary payer then makes payment based on any amount the primary payer did not cover. We make our determination of whether we are the "primary" or "secondary" payer according to the Order of Benefit Determination Rules of the Group Coordination of Benefits Model Regulation, Section 5, provided by the National Association of Insurance Commissioners (NAIC). The NAIC guidelines say that, in general, if the other payer has no Coordination of Benefits provision or if they have a provision that differs from ours, they are primary. If they use the same NAIC provisions we use, we determine who is primary as follows:

- the payer covering a patient as an employee (Subscriber) is primary to a payer who covers him or her as a Dependent;
- if a Child or Over-age Dependent is the patient, we use the NAIC "Birthday Rule," which makes the coverage of the parent whose birthday is earlier in the calendar year (without regard to year of birth) the primary payer; and

- when the above two rules don't apply, the coverage with the earliest effective date is primary and the other is secondary.

Coordination of Benefits for Children of Divorced Parents

If two or more plans cover a Dependent Child of divorced or separated parents, a court often decrees that one parent should be responsible for the health insurance of the Child. In that case, the plan of the parent with that responsibility is primary. If no such decree exists, benefits are determined in this order:

- the plan of the parent with custody of the Child; then
- the plan of the Spouse/Party to a Civil Union of the parent with custody (if he or she covers the Child); then
- the plan of the parent who does not have custody of the Child; and finally
- the plan of the Spouse/Party to a Civil Union of the noncustodial parent (if he or she covers the Child).

If a court decrees that parents will share custody of the Child, without stating that one parent is responsible for health care expenses for the Child, we use the "Birthday Rule" described in the last section.

In an Accident

If you have an accident and you are Covered for accident-related expenses under any of the following types of coverage, the other payer is primary and we are secondary:

- no-fault auto insurance;
- Group auto insurance;
- traditional fault-type auto insurance;
- uninsured or underinsured motorist insurance;
- automobile-medical payment insurance;
- home owner's insurance;
- personal injury protection insurance;
- financial responsibility insurance;
- medical reimbursement insurance coverage that you did not purchase; or
- any other property and liability insurance providing medical payment benefits.

Reimbursement

If another health plan provides benefits that we should have paid, we have the right to reimburse the other health plan directly. That payment satisfies our obligation under your Contract.

Medicaid and CHAMPUS

We will always be "primary" payer to Medicaid or CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). CHAMPUS and Medicaid are always secondary payers.

Subrogation

To the extent that we advance benefits under your Contract, we shall be subrogated to your rights of recovery from any person or organization that caused or contributed to your illness or injuries or paid as a result of your illness or injuries. This means that:

- If you receive medical treatment for injuries or illness caused by another party, and we advance benefits for any part of that medical treatment, you shall pay us all amounts you recover by suit, settlement

or otherwise from any third party, its insurer or your insurer, to the extent of the benefits advanced under your Contract. In appropriate cases, we may reduce the amounts you owe us by a proportionate share of the reasonable and necessary attorneys' fees and costs incurred by you to obtain your recovery. We reserve the right to bring a lawsuit in your name or in our name against any responsible party or parties to recover benefits we have advanced or to settle our claim for such benefits with such responsible party or parties.

- This right of subrogation extends to and includes any recovery you may have under no-fault auto insurance, Group auto insurance, traditional fault-type auto insurance, uninsured or underinsured motorist insurance, automobile-medical payment insurance, home owner's insurance, personal injury protection insurance, financial responsibility insurance, medical reimbursement insurance coverage that you did not purchase, or any other property and liability insurance providing medical payment benefits.
- You shall take such action, furnish such information and assistance, and execute such papers (including a reimbursement agreement) as we may require to enforce our rights, and you shall take no action prejudicing our rights and interests under your Contract.
- If you refuse to pay us or to provide the necessary information, we may take legal action against you to recover amounts paid. In the event it is necessary for us to take such action, you will also be responsible for our attorney's fees and expenses in collecting the amounts owed by you. Your future benefits may be reduced or withheld to recover monies owed to us.
- You agree that you will not settle your claim without first notifying us. We reserve the right to compromise the amount of our claim if, in our opinion, it is appropriate to do so. We shall have a lien on your recovery from the person causing you illness or injury for which we have advanced benefits.

Chapter Seven
Membership

Remember, when you add or remove Dependents, your type of membership (individual, two-person, or family) may change.

You may add or remove Dependents from your membership under the conditions noted in this Chapter. To do this, obtain a Group Enrollment Form from your Group Benefits Manager. Fill out the form and give it to your Group Benefits Manager. He or she will submit this request form to us.

You must cover either all or none of your Dependents who are eligible under your Contract, unless otherwise ordered by a court of law.

Adding Dependents

You may add a Dependent when any of the following events occurs:

Open Enrollment

You may add Dependents for any reason on the Group's open enrollment date. If we receive your request before this date, we will make the change effective on the open enrollment date. If we receive your request during the month in which your open enrollment occurs, we will make the change effective on the first of the following month.

If you belong to a small Group (a Group of less than 50 employees) plan, we do not impose open enrollment periods. Provisions in your Contract regarding open enrollment do not apply if you belong to a small Group. Your Group or association may do so, however (most associations do). Check with your Group Benefits Manager for information.

Marriage/Civil Union

If we receive your application within 31 days after the date of marriage/Civil Union, your new type of membership is effective the first day of the month following the date of marriage/Civil Union. If we receive your request within 32 to 60 days after the date of your marriage/Civil Union, your new membership becomes effective the first day of the month after we receive your request.

If you fail to add your new Dependent within 60 days of your marriage/Civil Union, you must wait until an open enrollment date to do so. If you belong to a small Group (a Group of less than 50 employees) plan, check with your Group Benefits Manager to see if your Group or association imposes an open enrollment period.

Birth or Adoption

If you already have a family membership, we cover your new Child from the date of birth, legal placement for adoption or legal adoption. You should, however, notify us of your family addition within 31 days.

If you do not have a family membership, we cover your Child for 31 days after:

- birth;
- legal placement for adoption (when placement occurs prior to adoption finalization); or
- legal adoption (when placement occurs at the same time as adoption finalization).

However, we must receive your application for a membership change in order to continue benefits for the Child past 31 days. If we receive your request within the 31 days:

- the Child's effective date is retroactive to the date of birth, placement for adoption or adoption; and
- the new type of membership is effective the first day of the month following birth, placement for adoption or adoption.

If we receive your request within 32 to 60 days, the Child's membership and the new type of membership are effective the first day of the month following our receipt of your request.

If you fail to add your new Dependents within 60 days, you must wait until an open enrollment date to do so. If you belong to a small Group (a Group of less than 50 employees) plan, check with your Group Benefits Manager to see if your Group or association imposes an open enrollment period. Dependents who do not become covered within 94 days must fulfill their own waiting periods for pre-existing conditions.

Spouse's/Party to a Civil Union's Loss of Coverage

A Spouse/Party to a Civil Union and any Dependents covered under the Spouse's/Party to a Civil Union's health coverage with another health plan are eligible for membership under your Contract if the Spouse/Party to a Civil Union loses his or her group health coverage or terminates employment. If you fail to add your Spouse/Party to a Civil Unionand/or Dependents within 31 days after your Spouse/Party to a Civil Union loses coverage, you must wait until an open enrollment date to do so.

Court-ordered Dependents

The effective date of a court-ordered addition of a Dependent is the first of the month after we receive your request. The request must include proof of the court order.

Over-age Dependents

Dependent Students

You may include unmarried, full-time students (taking 12 credits or more per semester) between the ages of 19 and 25 as Dependents on your membership. To do this, you must provide us with the following information:

- written notice of your Child's student status on our Student Certification form; and
- written proof (acceptable to us) of student status.

If a Child is a full-time student on his or her 19th birthday, he or she may continue on your membership without meeting new waiting periods for Pre-existing Conditions. To continue the membership, however, we must receive the request before the first of the month following the student's 19th birthday.

If your Child becomes a student after his or her 19th birthday, waiting periods may apply. If we receive your request for student status within 60 days after he or she becomes a student, the student's coverage is effective the

first of the month following our receipt of your request. If we don't receive the request within 60 days, you must wait until an open enrollment date to add the student to your membership. If you belong to a small Group (a Group of less than 50 employees) plan, check with your Group Benefits Manager to see if your Group or association imposes an open enrollment period.

Dependent student coverage ceases the first day of the month after a student:

- marries;
- is no longer a full time student;
- no longer lives in the Subscriber's home; or
- turns 25 years of age.

Incapacitated Dependents

In order to provide continued coverage for an Incapacitated Dependent, we must receive the following:

- an application form for Incapacitated Dependents (which you may obtain from our Customer Service Department); and
- Physician certification of the extent and nature of the handicap.

Our medical director must review the above information and deem the Dependent Incapacitated before we will provide coverage.

We must receive the above information within 31 days of the date the individual would no longer be an eligible Dependent if he or she were not Incapacitated.

Removing Dependents

You must remove Dependents from membership with us if any of the following events occurs:

- a Dependent dies;
- the Subscriber and Spouse/Party to a Civil Union divorce (Spouse is removed);
- a child no longer meets the definition of a Child (marries, turns 19 or no longer lives in the Subscriber's home);
- an Incapacitated Dependent is no longer Incapacitated; or
- a student ceases to be a student.

Dependents become ineligible for coverage under your Contract at the end of the month after the event occurs.

Termination Of Group Coverage

Termination of Coverage by You, by the Group or by Us

You or your Group may terminate this Contract without cause at the end of any calendar month by giving 15 days prior written notice. BCBSVT may terminate this Contract in accordance with State and Federal law.

Upon Contract termination, we refund your Group the amount of any unearned prepaid subscription rates we hold. Such payment constitutes a full and final discharge of all our obligations under this Contract, unless otherwise required by law. We will continue to provide benefits for all Covered services received before the date of termination.

Default in Subscription Payment

If we do not receive your payment on the due date:

- we will mail you a cancellation notice; and
- this Contract automatically terminates after midnight on the 14th day after we send you a cancellation notice.

We consider a termination for nonpayment a cancellation by you.

Fraud or Misrepresentation

If you obtain or attempt to obtain coverage or benefits through material fraud or misrepresentation, this Contract is void.

Contract Reinstatement

We may reinstate a terminated Contract solely at our discretion and only on such terms and conditions as we decide, as allowed by law.

Voidance and Modification

Unless your application or an exact copy of it is included in, or attached to, your Contract, no representation you make on your application for a contract shall:

- make this Contract void; or
- be used in any legal proceeding under your Contract.

Only an officer of Blue Cross and Blue Shield of Vermont is authorized to bind us legally by changing or waiving any provisions of your Contract.

Benefits After Termination of Coverage

If you are entitled to benefits for a continuous total disability, as defined by the Social Security Act, existing on the cancellation date, we provide benefits for services until the earlier of:

- the date your disability ends;
- 12 months beyond the date of cancellation; or
- the date you exhaust your benefit maximums.

Continuation of Group Coverage

Various state and federal laws may entitle you to continue your Group coverage after it would otherwise terminate. Contact your Group to determine which laws apply to your circumstances.

Conversion to Direct-pay Coverage

When continuation of Group coverage ceases, you may be eligible for direct-pay coverage. If so, we will give you the opportunity to convert without a break in coverage. To do this, your direct-pay coverage must be effective within 30 days after your Group coverage terminates.

Remember, the terms of your Contract with us may change if you transfer from one group to another, or change to direct-pay coverage.

If your Group cancels coverage with us and obtains coverage with another health insurer or you are otherwise eligible for group coverage, we cannot continue your Group coverage or offer you direct-pay coverage.

Medicare

Please note that this is not a Medicare Supplement Contract. We will not provide benefits under this Contract if you are Medicare-eligible unless otherwise required or permitted by federal law. Contact your Group Benefits Manager to determine eligibility for the Medicare supplemental Certificate offered through your Group. If you are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from the company.

Chapter Eight
General Contract Provisions

Applicable Law

This Contract is intended for sale and delivery in, and is subject to the laws of the United States and the State of Vermont.

Entire Agreement

Your Contract is the entire agreement between you and us. Subject to applicable state and federal laws, you have no rights or privileges not specifically provided in this Contract. This Contract may only be changed in writing with the approval of the Vermont Department of Banking, Insurance, Securities and Health Care Administration. Notification of any change in this Contract will be in accordance with applicable law.

Severability Clause

If any provisions of your Contract are declared invalid or illegal for any reason, the remaining terms and provisions will remain in full force and effect.

Nonwaiver of Our Rights

Occasionally, we may choose not to enforce certain terms or conditions of your Contract. This does not mean we give up the right to enforce these terms or conditions later.

Term of Contract

Coverage continues from month to month until this Contract is discontinued, terminated or voided as allowed by this Contract.

Subscription Rate

Amount of Subscription Rate

We have different rates for single and multi-person memberships. Your Group's rate or rating formula has been filed with, and approved by, the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

Changes in the Subscription Rate

We may change rates only if we receive approval from the Vermont Department of Banking, Insurance, Securities and Health Care Administration. We will notify your Group of any rate change in accordance with state law.

Subscription Rate Payments

The subscription rate is payable in advance directly to us. We allow no more than a ten-day grace period for payment.

Subscriber Address

You (the Subscriber) must notify us, in writing or by phone, of any change of address. Call the Customer Service number listed on your I.D. Card or mail your change of address to:

Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186

We send all notices by first class postage to the Subscriber's address that we have on file. This constitutes our full responsibility to notify the Subscriber, regardless of whether the Subscriber receives such notice.

Third Party Beneficiaries

All members Covered under this Contract (except the Subscriber) shall be third party beneficiaries to the Contract.

Chapter Nine
Definitions

Note: Subject to your rights under this Contract and the law that allows you to appeal a denial of benefits, we have the authority to interpret and apply the terms of this Contract and to determine whether and to what extent you have coverage for a requested service, even when a Provider has prescribed or recommended the service.

Acute (Care): (treatment of) an illness, injury or condition, marked by a sudden onset or abrupt change of your health status that requires prompt medical attention. Acute Care may include hospitalization of limited duration. Acute Care is intended to produce measurable improvement or maximum rehabilitative potential within a reasonable and medically predictable period of time.

Allowed Price: the amount we consider reasonable for a Covered service or supply.

Ambulance: a specially designed and equipped vehicle for transportation of the sick and injured.

Benefit: the amount we pay for a Covered service or supply as shown on your *Explanation of Benefits*.

Certificate: this document.

Child: (refer to Dependent definition)

Chiropractor: a duly licensed Doctor of Chiropractic, acting within the scope of his or her license.

Chronic Care: treatment of an illness, injury or condition that is:

- not necessarily directed toward alleviation or prevention of an Acute condition; and
- of long duration without any reasonably predictable date of termination.

Chronic conditions may be marked by recurrences of conditions requiring Acute Care on a periodic basis.

Civil Union: a relationship established between two persons of the same sex pursuant to 15 V.S.A. Chapter 23 that entitles the parties to the benefits and protections of spouses and subjects them to the responsibilities of spouses.

Coinsurance: a percentage of our Allowed Price *you must pay*, as shown on your *Outline of Coverage*, after you meet your Deductible. (Refer also to Chapter One.)

Contract: consists of:

- your *Outline of Coverage*, this *Certificate* and the documents listed on your *Outline of Coverage*;
- your Identification Card; and

- your application and any supplemental applications that you submit and we approve.

Your Contract is subject to all of our agreements with Preferred Providers and other Blue Cross or Blue Shield Plans, as amended from time to time.

Co-payment (Visit Fee): a fixed dollar amount *you must pay* for specific services, if any, as shown on your *Outline of Coverage*. (Refer also to Chapter One.)

Cosmetic: primarily intended to improve appearance.

Cover(ed): describes a service or supply for which you are eligible for benefits under your Contract.

Custodial Care: primarily designed to help in your daily living activities. Custodial Care is not primarily provided for its curative value. Custodial Care includes:

- help in walking, bathing, dressing and feeding;
- preparation of special diets;
- supervision over administration of medications; and
- care not requiring skilled nursing services.

Deductible: the amount *you must pay* toward the cost of specific services each calendar year before we pay any benefits. Your *Outline of Coverage* shows your Deductible amounts. (Refer also to Chapter One.)

Dependent: a Subscriber's Spouse, the other Party to a Subscriber's Civil Union, or a Subscriber's Child or Over-Age Dependent (refer to Chapter Seven) Covered under this Contract.

Child: a Subscriber's unmarried stepchild (through marriage or Civil Union), son or daughter, whether biological or legally adopted (including a child living with the adoptive parents during a period of probation); or a child for whom the Subscriber is legal guardian.

A Child must be under age 19 and live in the Subscriber's household unless coverage has been ordered by a court of law.

Over-age Dependent: a full-time student as described in our membership section or Incapacitated Dependent as defined in this section.

Party to a Civil Union: a person with whom the Subscriber has entered into a legally valid Civil Union.

Spouse: the Subscriber's Spouse under a legally valid marriage between persons of the opposite sex.

Diagnostic Services: approved services, ordered by a Physician or podiatrist, to determine a definite condition or disease. Diagnostic Services include:

- imaging (radiology, X-rays, ultrasound and nuclear);
- studies of the nature and cause of disease (laboratory and pathology tests);
- medical procedures (ECG and EEG);
- allergy testing (percutaneous, intracutaneous, patch and RAST testing); and
- mammography.

Durable Medical Equipment (DME): equipment that:

- requires a prescription from your Physician;
- is primarily and customarily used only for a medical purpose;
- is appropriate for use in the home;
- is designed for prolonged and repeated use; and
- is not generally useful to a person who is not ill or injured.

DME includes wheelchairs (manual and electric), hospital-type beds, walkers, canes, crutches, kidney machines, ventilators, oxygen, monitors, pressure mattresses, nebulizers, traction equipment, bili blankets, bili lights and respirators.

DME does not include items such as air conditioners, bathroom equipment, chair lifts, dehumidifiers, whirlpool baths, exercise equipment, motorized scooters and other equipment that has both nonmedical and medical uses.

Emergency Medical Condition: the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- placing the member's physical or mental health in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Services: health care items and services furnished or required to evaluate and treat an Emergency Medical Condition.

Experimental or Investigational Services: health care items or services that are either not generally accepted by informed health care Providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or are not proven by Medical or Scientific Evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

Facility (Facilities): the following institutions or entities:

- Ambulatory Surgical Centers
- Birthing Centers
- Community Mental Health Centers
- General Hospitals *
- Home Health Agencies/Visiting Nurse Associations *
- Physical Rehabilitation Facilities *
- Residential Treatment Center*
- Skilled Nursing Facilities *
- Substance Abuse Rehabilitation Facilities *
- Psychiatric Hospitals *

* Facilities further defined in this Chapter.

General Hospital: a short-term, Acute Care hospital that:

- is a duly licensed institution;
- primarily provides Diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick people by or under the supervision of Physicians;
- has organized departments of medicine and major Surgery; and

- provides 24-hour nursing services by or under the supervision of registered nurses.

Group: the organization that has agreed to forward subscription rates due under your Contract.

Group Benefits Manager: the individual (or organization) that has agreed to forward all subscription rates due under your Contract. The Group Benefits Manager is the agent of the Subscriber. Your Group Benefits Manager has no authority to act on our behalf and is not our employee or agent. ***We disclaim all liability for any act or failure to act by your Group Benefits Manager.***

Home Health Agency/Visiting Nurse Association: an organization that provides skilled nursing and other services in your home. It must be certified under Title 18 of the Social Security Act, as amended (Medicare-certified).

Hospice: an organization engaged in providing care to the terminally ill. It must be federally certified to provide Hospice services or accredited as a Hospice by the Joint Committee for Accreditation of Healthcare Organizations.

Incapacitated: A Dependent who meets our definition of Child (except he or she is over the age of 19) and who:

- is deemed, in our judgement as based on a clear demonstration of medical necessity, to be incapable of self-support by reason of cerebral palsy, epilepsy, physical or developmental disability, mental illness or retardation;
- became incapable of self-support when he or she was a Child or a student; and
- is chiefly dependent on the Subscriber or the Subscriber's estate for support and maintenance.

Include(s), Including: to have as a part or member of a whole; contain. To put into a group, class or total. "Include," followed by a list, does not imply the list is complete, unless used with the word "only."

Inpatient: a patient at a Facility who is admitted and incurs a room and board charge. We compute the length of an Inpatient stay by counting either the day of admission or the day of discharge, but not both.

Intensive Outpatient Programs: programs that have the capacity for planned, structured service provision of at least two hours per day and three days per week. The services offered address mental health or substance abuse-related disorders and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring. These services would include multiple or extended treatment, rehabilitation, or counseling visits or professional supervision and support.

Investigational: (see Experimental)

Medical Care: nonsurgical treatment of an illness or injury by a Professional Provider.

Medical or Scientific Evidence: the following sources:

- peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published Chapters for review by experts who are not part of the editorial staff;
- peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);
- medical journals recognized by the federal Secretary of Health and Human Services, under Section 1861 (t)(2) of the federal Social Security Act;
- the following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and the United States Pharmacopoeia-Drug Information;
- findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- peer-reviewed abstracts accepted for presentation at major medical association meetings.

Medically Necessary Care: health care services including Diagnostic Services, preventive services and aftercare appropriate, in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. Medically Necessary Care must be consistent with generally accepted practice parameters as recognized by health care Providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and:

- help restore or maintain the member's health;
- prevent deterioration of or palliate the member's condition; or
- prevent the reasonably likely onset of a health problem or detect an incipient problem.

Even if a Provider prescribes, performs, orders, recommends or approves a service or supply, we may not consider it Medically Necessary.

Mental Health Condition: nervous or mental condition, only as listed in the Mental Disorders Section in the International Classification of Diseases Manual (ICD-9-CM). The following conditions may be covered under other sections of this Certificate:

- conditions related to Substance Abuse (refer to Substance Abuse definition);
- hyperkinetic syndrome of childhood (ICD-9-CM codes 314.00 through 314.99),

except for intervention for Acute, brief episodes when other diagnoses are present;
- specific delays in development (ICD-9-CM codes 315.00 through 315.99);
- psychic factors associated with diseases classified elsewhere in the ICD-9-CM (ICD-9-CM code 316.00); and
- mental retardation (ICD-9-CM codes 317.00 through 319.99), except for interventions for Acute, brief episodes when other diagnoses are present.

Mental Health Disorders also include only the following nervous or mental conditions as listed in the "V Codes" Section in the International Classification of Diseases Manual (ICD-9-CM):
- personal history of mental disorder (ICD-9-CM codes V11.00 through V11.99);
- psychological trauma (ICD-9-CM code V15.40);
- psychiatric condition (ICD-9-CM code V17.00);
- other family circumstances and other psychosocial circumstances (ICD-9-CM codes V61.00 through V62.99); and
- observation for suspected mental condition (ICD-9-CM code V71.00).

To find out if your condition fits this definition, please call your Network Provider.

Mental Health Services: services to diagnose or treat a Mental Health Condition.

Nonpreferred: (see Provider)

Occupational Therapy: therapy that promotes the restoration of a physically disabled person's ability to accomplish the ordinary tasks of daily living or the requirements of the person's particular occupation. Occupational therapy must include constructive activities designed and adapted for a specific condition.

Other Provider: one of the following entities:
- Ambulance
- Preferred Home Infusion Therapy Provider
- Medical Equipment/Supply Provider (DME)
- Pharmacy

Off-label (use of a drug): use of a drug for other than the particular condition for which approval was given by the Federal Drug Administration.

Outline of Coverage: the summary of your Contract benefits.

Outpatient: a patient who receives services from a Professional or Facility while not an Inpatient.

Parties to a Civil Union: (see Dependent)

Pharmacist: a person who is legally licensed to practice the profession of Pharmacy.

Pharmacy: any establishment that is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

Physical Rehabilitation Facility: a Facility that primarily provides rehabilitation services on an Inpatient basis. Care consists of the combined use of medical, pharmacy, social, educational and vocational services. These ser-

vices enable patients disabled by disease or injury to achieve continued improvement of functional ability. Services must be provided by or under the supervision of Physicians. Nursing services must be provided under the supervision of Registered Nurses (RNs).

Physical Therapy: therapy that relieves pain of an Acute condition, restores function, and prevents disability following disease, injury or loss of body part.

Physician(s): doctors of medicine (including psychiatrists), dental Surgery, medical dentistry or osteopathy.

Consulting: describes a Professional Provider whom your Attending Physician asks for Professional advice about your condition**.**

Pre-existing Condition: a condition for which you have sought medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment has been recommended during the six months before you became Covered under this Contract.

Preferred: (see Provider)

Prescription Drugs: drugs that are:

- prescribed by a Physician for a medical condition;
- FDA-approved; and
- approved by us for reimbursement for the specific medical condition being treated or diagnosed.

Prior Approval: the required approval that you must obtain from us before you receive specific services noted in your Contract. In some cases, we require that you get our Prior Approval in writing. *If you do not obtain approval from us before you receive certain services, benefits may be reduced or not provided. See page 8 for more information about the Prior Approval Program. For a list of services that require Prior Approval, see your* Outline of Coverage.

Professional: one of the following practitioners:

- audiologists
- Chiropractors (as further defined in this Chapter)
- clinical mental health counselors
- clinical psychologists
- clinical social workers
- independent clinical laboratories
- certified nurse midwives (not lay or professional midwives)
- certified registered nurse anesthetists
- licensed practical nurses (LPNs)
- nurse practitioners
- nutritional counselors
- registered nurses (RNs)
- optometrists
- Physicians (as further defined in this Chapter)
- podiatrists
- substance abuse counselors
- therapists (occupational, physical and speech)

Some Professionals must be in our Network or have a Preferred Provider agreement with us for their services to be Covered. See page 7.

Provider: An entity listed under the definition of Facility, Professional or Other Provider that is:

- approved by us;
- licensed and/or certified where required; and
- acting within the scope of that license and/or certification.

Network Provider: any Provider identified as being a member of one of our Networks (for example, our Pharmacy Network or our Mental Health and Substance Abuse Provider Network.) You may obtain a Directory of Network Providers from your Group Benefits Manager or from our customer service department.

For some types of service, we do not provide benefits if you do not use a Network Provider.

Preferred Provider: any Provider that has a Preferred Provider agreement with us; or any Provider located out of state that has a similar agreement with another Blue Cross and Blue Shield Plan. (See also Nonpreferred Provider, below.)

For some types of service, we do not provide benefits if you do not use a Preferred Provider. (They are listed on page 7.)

Nonpreferred Provider: a Provider that does not meet the definition of a Preferred Provider.

For some types of service, we do not provide benefits if you use a Nonpreferred Provider. (They are listed on page 7.)

Psychiatric Hospital: a Facility that provides Diagnostic and therapeutic facilities for the diagnosis, treatment and Acute Care of mental and personality disorders. A staff of Physicians must direct care. A Psychiatric Hospital must:

- provide 24-hour nursing service by or under the supervision of registered nurses (RNs);
- keep permanent medical history records; and
- be a private psychiatric or public mental hospital, licensed in the state where it is located.

Reconstructive: describes surgery to correct deformities resulting from or present at birth, injury or disease, or that is Medically Necessary following injury or disease.

Residential Treatment Center: a facility that is licensed at the residential intermediate level or as an intermediate care facility (ICF) and provides Residential Treatment Program services.

Residential Treatment Program: a 24-hour level of care that provides patients with long-term or severe mental disorders or substance abuse-related disorders with residential care. Care is medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. Care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential care also includes training in the basic

skills of living as determined necessary for each patient.

Respite Care: care that relieves family members or care-givers by providing temporary relief from the duties of caring for Covered terminally ill patients. Respite Care is provided in a General Hospital or in your home, whichever is most appropriate.

Skilled Nursing Facility: a Facility that primarily provides 24-hour Inpatient skilled nursing care and related services. Physicians provide or direct services. Facilities must keep permanent medical history records. The Facility is not, other than incidentally, a place that provides:

- minimal care, Custodial Care, ambulatory care, or part-time care services;
- care or treatment of Mental Health Disorders, Substance Abuse or pulmonary tuberculosis; or
- rehabilitation.

Speech Therapy: therapy to correct speech impairment resulting from an Acute disease or occurrence.

Spouse: (see Dependent)

Subscriber: the individual who enters into this Contract with us.

Substance Abuse: Substance Abuse conditions only as listed in the Mental Disorders Section in the International Classification of Diseases Manual (ICD-9-CM) as follows:

- alcohol and drug psychoses (ICD-9-CM codes 291.00 through 292.99);
- alcohol dependence syndromes (ICD-9-CM codes 303.00 through 303.99);
- drug dependence (ICD-9-CM codes 304.00 through 304.99); and
- non-dependent abuse of drugs (ICD-9-CM codes 305.00 through 305.99), except tobacco use disorder (ICD-9-CM code 305.10) and other, mixed or unspecified drug abuse (ICD-9-CM code 305.90).

Substance Abuse Rehabilitation Facility: a Facility that primarily provides 24-hour care seven days per week rehabilitation treatment for Substance Abuse. Facility must offer sufficient availability of medical and nursing services to manage ancillary detoxification needs. Treatment must follow a written plan. Facilities located in Vermont must be state-approved. The Joint Commission for Accreditation of Rehabilitation Facilities must accredit Out-of-state Facilities.

Surgery: generally accepted invasive, operative and cutting procedures. Surgery includes:

- specialized instrumentations;
- endoscopic examinations;
- treatment of burns;
- correction of fractures and dislocations; and
- anesthesia and the administration of anesthetics to obtain general or regional (but not local) muscular relaxation, loss of sensation or loss of consciousness during a Covered procedure.

Urgent Services: services for a condition that causes symptoms of sufficient severity, including severe pain, that the absence of medical attention within 24 hours could reasonably

be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- placing the member's physical or mental health in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Visit Fee (Co-payment): a form of Co-payment for home, office or Facility visits. (Refer also to our Co-payment definition and Chapter One.)

We, Us, Our: Blue Cross and Blue Shield of Vermont, or any designated agents or reinsurers (where applicable) of Blue Cross and Blue Shield of Vermont.

Well-Child Care: normal periodic evaluation of a well child.

You, Your: the Subscriber and any Dependents Covered under the Subscriber's Contract.

More Information about Your Contract

You hereby expressly acknowledge your understanding that your Contract constitutes a contract solely between you and Blue Cross and Blue Shield of Vermont, that we are an independent corporation operating under a controlled affiliate license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting us to use the Blue Cross and Blue Shield Service Marks in the State of Vermont, and that we are not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into your Contract based upon representations by any person other than us and that no person, entity, or organization other than us shall be held accountable or liable to you for any of our obligations to you created under your Contract. This paragraph will not create any additional obligations whatsoever on our part, other than those obligations created under other provisions of your Contract.

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